CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 384 **Date: December 1, 2004**

CHANGE REQUEST 3541

NOTE: This transmittal replaces transmittal 383, dated November 26, 2004, which is rescinded. This CR is no longer Sensitive and can be posted to your Website.

SUBJECT: Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)

I. SUMMARY OF CHANGES: This change request seeks to provide implementing instructions to Medicare standard systems for IPF PPS. In addition to providing the policy, we are also providing business requirements and information on the data elements of the Provider-Specific File.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 1, 2005
IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/ 20.2.3.1/Provider-Specific File
R	3/ Addendum A

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

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SUBJECT: Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)--IMPLEMENTATION

I. GENERAL INFORMATION

A. Background: IPFs are certified under Medicare as inpatient psychiatric hospitals and distinct psychiatric units of acute care hospitals which have been excluded from the hospital inpatient PPS under §1886(d)((1)(B)(i) of the Social Security Act, and are included for purpose of Medicare payment. This PPS will replace the existing reasonable cost-based payment system under which the IPFs are currently paid.

Statutory Requirements:

The Balanced Budget Refinement Act (BBRA) of 1999 requires that a budget neutral, per diem PPS for IPFs include an adequate patient classification system reflecting the differences in patient resource use and costs among psychiatric hospitals and psychiatric units of acute care hospitals be implemented for cost reporting periods beginning on or after October 1, 2002.

This final rule finalizes the provisions set forth in the November 28, 2003 proposed rule. Payments for IPF services delivered for **cost reporting periods starting** on or after January 1, 2005 will be based on the policies set forth in the November 15, 2004 final rule (69 FR 66922).

B. Policy:

Affected Medicare Providers

IPFs are certified under Medicare as inpatient psychiatric hospitals, which means, an institution that is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of the mentally ill patients, maintains clinical records necessary to determine the degree and intensity of the treatment provided to the mentally ill patient, and meets staffing requirements sufficient to carry out active programs of treatment for individuals who are furnished care in the institution. A distinct part psychiatric unit must be certified and meet the clinical record and staffing requirements in § 412.27 to be considered a "psychiatric hospital". Both psychiatric hospitals and distinct part psychiatric units of acute care hospitals are referred to in the IPF PPS rule as "inpatient psychiatric facilities."

- The provider number ranges for IPFs are from xx-4000 – xx-4499, xx-Sxxx, and xx-Mxxx.

- Veterans Administration Hospitals, hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403, hospitals that are reimbursed in accordance with demonstration projects authorized under §402(a) of Public Law 90-248 (42 U. S. C. 1395b-1) or §222(a) of Public Law 92-603 (42 U. S. C. 1395b-1) are not included in the IPF PPS, and Critical Access Hospitals (CAHs) and nonparticipating hospitals furnishing emergency services to Medicare beneficiaries. Payment to foreign hospitals will be made in accordance with the provisions set forth in §413.74 of the regulation. See §412.22(c).

- IPFs in acute care hospitals that are presently paid in accordance with demonstration projects would be exempt from the IPF PPS, as they would also be paid in accordance with the demonstration project. All other IPF units of acute care hospitals not paid in accordance with a demonstration project and psychiatric hospitals would be exempt and therefore would be paid under the IPF PPS.

- Freestanding IPFs (provider numbers xx-4000 – xx-4499) in Maryland will be paid under the IPF PPS. Psychiatric distinct part units located in an acute care hospital identified by 'S' will be waived from the IPF PPS. Currently there are no CAHs in Maryland, so there are no 'M' providers in Maryland at this time.

Payment Provisions Under the IPF PPS

Section 124 of Public Law 106-113, the BBRA of 1999, requires the implementation of Federal payment rates under PPS for IPFs[*]. The BBRA confers broad authority on the Secretary to determine how the IPF PPS is structured. Based on the authority of BBRA, we have established a Federal per diem base rate and various facility level and patient-level adjustments, in order to ensure that payment most accurately reflects cost.

Federal Per Diem Base Rate:

- Presently, each IPF is paid on a hospital-specific basis under the TEFRA payment system. When the IPF PPS is totally phased in, after the 3-year transition period, all payments to IPFs will be based on a standardized amount per day, a "Federal per diem base rate."

- The standardized Federal per diem base rate, adjusted for budget neutrality (behavioral offset, outlier payments, stop-loss payments (stop loss is at settlement), is $575.95.

- The Federal per diem base rate is adjusted by all applicable patient and facility characteristics.

Budget Neutrality:

- The BBRA requires that total payments under the PPS must equal the amount that would have been paid if the PPS had not been implemented.

[*] Presently, each IPF is paid on a hospital-specific basis under the TEFRA payment system. When the PPS is totally phased-in, after the 3-year transition period, all payments to IPFs will be based on a standardized amount per day, a "Federal per diem base rate."

- The components of the budget neutrality adjustment are the outlier policy, stop-loss provision and behavioral offset. The estimated outlier payments were calculated on a per-case basis. The estimated stop-loss payments were based on a comparison of the aggregate TEFRA payments to aggregate IPF PPS payments.

Standardization Factor:

- A standardization factor was applied to the average per diem cost of an IPF stay to account for the additional payments to IPFs generated by payment adjustments.

- The standardization factor was calculated by dividing total estimated payments under the TEFRA payment system by estimated payments under the IPF PPS.

- The standardization factor for FY 2005 is 0.8367.

Annual Update:

- The first update to the IPF PPS will occur on July 1, 2006 and every July 1 thereafter.

- The first IPF PPS update notice will be published in the spring of 2006. The notice will include updates to: the Federal per diem base rate using the excluded hospital with capital market basket, the hospital wage index and the fixed dollar loss threshold amount.

PLEASE NOTE: The annual update cycle is separate from the 3-year transition period.

The annual updates are to update adjustments factors (excluded hospital with capital market basket, hospital wage index, fixed dollar loss threshold) for the IPF PPS.

The 3-year transition period is provided to allow IPFs to adjust from the current TEFRA based payment system to the IPF PPS payment system as smoothly as possible. The transition is applied based on the IPF's cost reporting period.

Beneficiary Liability

Because this payment system is a per diem, there are no grace days applicable.

Benefit Application

The psychiatric benefit application (190 days) applies to freestanding psychiatric hospitals per §409.62. The 190-lifetime limitation (§409.62) does not apply to psychiatric certified distinct part units. Section 409.62 states, "There is a lifetime maximum of 190 days on inpatient psychiatric hospital services available to any beneficiary. Therefore, once an individual receives benefits for 190 days of care in a psychiatric hospital, no further benefits of that type are available to that individual."

Patient Classification System:

The BBRA required the use of a patient classification system in the PPS for IPFs. Until further research can explain the difference in mental health resource utilization by different patient characteristics, the IPF PPS will provide adjustments for specific patient characteristics.

- IPFs will submit claims providing the ICD-9-CM code of the principal diagnosis.

- The patient claim will list an ICD-9-CM code, as the principal diagnosis, that will group to an existing CMS DRG used under the hospital inpatient PPS.

- Medicare beneficiaries with a psychiatric principal diagnosis that is included in one of the 15 DRGs selected for the DRG adjustment will receive the DRG adjustment and all other applicable adjustments through the patient stay.

- Medicare beneficiaries with a psychiatric principle diagnosis that does not group to one of the 15 DRGs selected for a DRG adjustment will receive the Federal per diem base rate and all other applicable adjustments, but will not receive the DRG adjustment for the stay.

- To classify the case to the appropriate DRG, the same GROUPER software (Version 22 for FY 2005) developed by 3M for the hospital inpatient PPS will be used and the PRICER will apply the adjustment factors for the various characteristics that reflect the resources used to treat the IPF patients.

Payment Rate

Payments to IPFs under the IPF PPS will be based on a single Federal per diem base rate including both the inpatient operating and capital-related costs (including routine and ancillary services), but not certain pass through costs (i.e. bad debts, direct graduate medical education, and blood clotting factors).

Federal Per Diem Base Rate	$575.95
Labor Share (0.72247)	$416.11
Non-Labor Share (0.27753)	$159.84

- This single Federal per diem base rate will be updated annually by the excluded hospital with capital market basket index.

- **To calculate an IPF PPS payment, follow the steps below:**

    1. Multiply the Federal Per Diem Base Rate by the labor share (0.72247).
    2. Multiply this amount by the appropriate wage index factor.
    3. Multiply the Federal Per Diem Base Rate by the non-labor share (0.27753).
    4. Multiply this amount by any applicable cost of living adjustment (COLA) (Alaska or Hawaii).

5. Add the adjusted labor portion of the Rate to the adjusted non-labor portion of the Rate.
6. Multiply this sum by the facility and patient level adjustment factors, including variable per diem payments, to calculate the final payment.

Patient-Level Adjustments

Patient-level adjustments include a DRG adjustment, comorbidity adjustment, an age adjustment and a variable per diem adjustment.

DRG Adjustment:

The IPF PPS has DRG specific adjustments for 15 DRGs. We will provide payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric DRG will receive a DRG adjustment and all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of our identified 15 psychiatric DRGs, the IPF will still receive the Federal per diem base rate and all other applicable adjustments.

The 15 DRG specific adjustments are as follows:

Types of DRGs	DRG Code	Adjustment Factors
Procedure w principal diagnosis of mental illness	DRG 424	1.22
Acute adjustment reaction	DRG 425	1.05
Depressive neurosis	DRG 426	0.99
Neurosis, except depressive	DRG 427	1.02
Disorders of personality	DRG 428	1.02
Organic disturbances	DRG 429	1.03
Psychosis	DRG 430	1.00
Childhood disorders	DRG 431	0.99
Other mental disorders	DRG 432	0.92
Alcohol/Drug use, LAMA	DRG 433	0.97
Alcohol/Drug, w CC	DRG 521	1.02
Alcohol/Drug, w/o CC	DRG 522	0.98
Alcohol/Drug use, w/o rehab	DRG 523	0.88
Degenerative nervous system disorders	DRG 12	1.05
Non-traumatic stupor & coma	DRG 23	1.07

Code First:

For Code First situations, the Code First rules still apply and providers should follow the applicable ICD-9-CM coding rules.

- "Code first" notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause.

- When a "code first" note is present and an underlying condition is present, the underlying condition should be sequenced first.

Code	Code First Instruction as of 2005 (Effective October 1, 2004) ICD-9-CM Disease
290.0	Code First the Associated neurological condition
290.10	Code First the Associated neurological condition
290.11	Code First the Associated neurological condition
290.12	Code First the Associated neurological condition
290.13	Code First the Associated neurological condition
290.20	Code First the Associated neurological condition
290.21	Code First the Associated neurological condition
290.3	Code First the Associated neurological condition
290.40	Code First the Associated neurological condition
290.41	Code First the Associated neurological condition
290.42	Code First the Associated neurological condition
290.43	Code First the Associated neurological condition
290.8	Code First the Associated neurological condition
290.9	Code First the Associated neurological condition
293	Code First Associated physical or neurological condition
293.0	Code First Underlying Physical condition as: Dementia in: 331.0, 330.1, 331.82, 345.0 though 345.9, 331.19, 094.1, 275.1, 333.4, 046.1, 340, 331.1, 446.0, 094.1,
293.1,	Code First Underlying Physical condition as: Dementia in: 331.0
293.81,	Code First Underlying Physical condition as: Dementia in: 331.0
293.82	Code First Underlying Physical condition as: Dementia in: 331.0
293.83	Code First Underlying Physical condition as: Dementia in: 331.0
293.84	Code First Underlying Physical condition as: Dementia in: 331.0
293.89	Code First Underlying Physical condition as: Dementia in: 331.0
293.9	Code First Underlying Physical condition as: Dementia in: 331.0
294.10	Code First Underlying Physical condition as: Dementia in: 331.0, 330.1, 331.82, 345.0 through 345.9, 331.19, 094.1, 275.1, 333.4, 046.1, 340, 331.1, 446.0, 094.1,
294.11	Code First Underlying Physical condition as: Dementia in: 331.0, 330.1, 331.82, 345.0 through 345.9, 331.19, 094.1, 275.1, 333.4, 046.1, 340, 331.1, 446.0, 094.1,
307.89	Code First Site of Pain
320.7	Code First Underlying disease as: 039.8, 027.0, 002.0, 033.0 through 033.9

- Code First example:

Diagnosis code 294.1 “Dementia in Conditions Classified Elsewhere” is designated as a “code first” diagnosis and appears in the ICD-9-CM as follows:

294.1 Dementia in Conditions Classified Elsewhere
Code first any underlying physical condition, as:

Dementia in:
Alzheimer’s disease (331.0)
Cerebral lipidosis (330.1)
Dementia with Lewy bodies (33.82)
Dementia with Parkinsonism (331.81)
Epilepsy (345.0 – 345.9)

Frontal dementia (331.19)
Frontotemporal dementia (331.19)
General paresis [syphilis] (094.1)
Hepatolenticular degeneration (275.1)
Huntington's chorea (333.4)
Jacob-Creutzfeldt disease (046.1)
Multiple sclerosis (340)
Pick's disease of the brain (331.11)
Polyarteritis nodosa (446.0)
Syphilis (094.1)

According to the "code first" requirements, the provider would code the appropriate physical condition first, for example, 333.4 "Huntington's chorea" as the primary diagnosis and 294.1 as the secondary diagnosis. The submitted claim goes through the CMS processing system that will identify the primary diagnosis code as non-psychiatric and search the secondary codes for a psychiatric code to assign a DRG code for adjustment.

Comorbidity Adjustment:

The IPF PPS has 17 comorbidity groupings, each containing ICD –9-CM codes of comorbid conditions. Each comorbidity grouping will receive a grouping specific adjustment. Facilities can receive only one comorbidity adjustment per comorbidity category, but can receive an adjustment for more than one cormorbidity category.

Description of Comorbidity	ICD-9CM Code	Adjustment Factor
Developmental Disabilities	317, 318.0, 318.1, 318.2, and 319	1.04
Coagulation Factor Deficits	2860 through 2864	1.13
Tracheotomy	51900 – through 51909 and V440	1.06
Renal Failure, Acute	5845 through 5849, 6363, 6373, 6383, 6393, 66932, 66934, 9585,	1.11
Renal Failure, Chronic	40301, 40311, 40391, 40402, 40403, 40412, 40413, 40492, 40493, 585, 586, V451, V560, V561, and V562	1.11
Oncology Treatment	1400 through 2399 WITH either V58.0 OR V58.1	1.07
Uncontrolled Type I Diabetes-Mellitus with or without complications	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093	1.05
Severe Protein Calorie Malnutrition	260 through 262	1.13
Eating and Conduct Disorders	3071, 30750, 31203, 31233, and 31234	1.12
Infectious Disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889**,** and 07950 through 07959	1.07
Drug and/or Alcohol Induced Mental Disorders	2910, 2920, 2922, 30300, and 30400	1.03
Cardiac Conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11
Gangrene	44024 and 7854	1.10
Chronic Obstructive Pulmonary Disease	49121, 4941, 5100, 51883, 51884, and V461	1.12
Artificial Openings - Digestive and Urinary	56960 through 56969, 9975, and V441 through V446	1.08
Severe Muscloskeletal and Connective Tissue Diseases	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029	1.09

Description of Comorbidity	ICD-9CM Code	Adjustment Factor
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897	1.11

Age Adjustment:

- The IPF PPS has an age adjustment with 9 age categories; under 45, over 80, and categories in five year groupings in between.

- Facilities will receive this adjustment for each day of the stay.

Age	Adjustment Factor
Under 45	1.00
45 and under 50	1.01
50 and under 55	1.02
55 and under 60	1.04
60 and under 65	1.07
65 and under 70	1.10
70 and under 75	1.13
75 and under 80	1.15
80 and over	1.17

Variable Per Diem Adjustment:

- The variable per diem adjustment is to account for the ancillary and certain administrative costs that occur disproportionately in the first days after admission to an IPF.

- The variable per diem adjustment declines each day of the patient's stay through day 21.

- After day 21, the variable per diem adjustment flattens out (remains the same) each day for the remainder of the patient's stay.

Day-of-Stay	Variable Per Diem Payment Adjustment*
Day 1— Facility Without a Full-Service Emergency Department	1.19
Day 1— Facility With a Full-Service Emergency Department	1.31
Day 2	1.12
Day 3	1.08
Day 4	1.05
Day 5	1.04
Day 6	1.02
Day 7	1.01
Day 8	1.01
Day 9	1.00
Day 10	1.00
Day 11	0.99
Day 12	0.99

Day-of-Stay	Variable Per Diem Payment Adjustment*
Day 13	0.99
Day 14	0.99
Day 15	0.98
Day 16	0.97
Day 17	0.97
Day 18	0.96
Day 19	0.95
Day 20	0.95
Day 21	0.95
Over 21	0.92

*The adjustment for day 1 would be 1.31 or 1.19 depending on whether the IPF has or is a psychiatric unit in an acute care hospital with a qualifying emergency department.

Facility-Level Adjustments

Facility-level adjustments include the hospital Wage Index, a Rural Location adjustment, a Teaching Status adjustment, and an Emergency Department adjustment (for full service Emergency Department).

Wage Index:

- The IPF wage index is based on the most current unadjusted, pre-reclassified data.
- The hospital wage index accounts for the geographic differences in labor costs.
- The Labor-Related share of the Federal per diem base rate is 72.247 percent.
- The COLA for Alaska or Hawaii is applied to the non-Labor share of the Federal per diem base rate.
- The Non-Labor share of the Federal per diem base rate is 27.753 percent.

Rural Location Adjustment:

There will be a 17% adjustment if a facility is located in a rural area. The rural adjustment factor is 1.17.

Teaching Status Adjustment:

Teaching facilities will receive an adjustment that is measured as one plus the ratio of interns and residents to the average daily census (ADC) raised to the power of 0.5150. The number of interns and residents is capped at the level indicated on the latest cost report submitted by the IPF prior to January 1, 2005.

Emergency Department (ED) Adjustment:

An adjustment is provided for the first day of a psychiatric stay for IPFs with emergency department (the adjustment is not made for patients who were in an acute hospital and were transferred to the IPF) that meet the following definition:

> A full-service ED means an ED or psychiatric units located in a hospital with EDs that are staffed and equipped to furnish a comprehensive array of emergency services **and** meets the definition of "provider-based status" [42 CFR 413.65] **and** meets the definition of a "dedicated emergency department" [42 CFR 489.24].
>
> "Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility that complies with the provisions of this section." [42 CFR 413.65]
>
> "Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least **one** of the following requirements:
>
> 1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;
>
> 2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
>
> 3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment." [42 CFR 489.24].

- If a provider believes that they qualify for the ED adjustment, then the provider should contact their fiscal intermediary (FI) and supply their FI with any necessary documentation.

- Fiscal Intermediaries will need to verify the documentation (note that it was received and reviewed), and then place the form into the provider's file. This is a one-time verification.

- An example of the wording that a provider's documentation should include, in order to verify that their ED meets the IPF PPS' ED definition, will be included in the training materials.

Other Adjustments:

Electroconvulsive Therapy (ECT) Adjustment:

- IPFs will receive a flat-rate adjustment, which is subject to wage index and COLA adjustments, for each ECT treatment furnished during the IPF stay.

- The ECT adjustment is based on the median CY 2005 outpatient hospital PPS hospital cost of $247.96.

COLA Adjustment:

There is a cost-of-living adjustment (COLA) for IPFs located in Alaska and Hawaii. COLA adjustments for Alaska and Hawaii were established by regression.

State Receiving COLA	COLA Adjustment Amount
Alaska	1.25
Hawaii, Honolulu County	1.25
Hawaii, Hawaii County	1.165
Hawaii, Kauai County	1.2325
Hawaii, Maui County	1.2375
Hawaii, Kalawao County	1.2375

Payment for Special Cases:

Payments for interrupted stays, outliers, and stop-loss are based on properly submitted bill by the IPFs, which are described in billing instructions.

Interrupted Stay:

- An interrupted stay is a case in which a patient is discharged from an IPF and is readmitted to the same or another IPF before midnight on the third consecutive day following discharge from the original IPF stay. Interrupted stays are considered to be continuous for the purposes of applying the variable per diem adjustment and determining if the case qualifies for outlier payment.

- An interrupted stay is treated as one stay and one discharge for the purpose of payment. (The IPF should hold the claim for three days to ensure there is not a readmission that soon.)

- The readmission will be added to the end of the original stay.

- For example, patient leaves IPF on 1/1 and returns to the same IPF on 1/3. This is considered an interrupted stay and the Occurrence span code 74 will show 1/1 – 1/2. Should the patient return to the IPF on 1/4, two bills will be allowed.

- In the cases where an IPF patient is discharged from IPF "A" and within 3 days is readmitted to IPF "B," and IPF "B" does not know about the patient's immediately preceding hospitalization in IPF "A," then 2 bills will be allowed.

- If fiscal intermediaries notice a trend that an IPF is consistently admitting, discharging and readmitting patients in order to receive the larger variable per diem payments associated with a patients first days of their stay, then the FI should review it as they see fit.

Outlier Adjustment:

Additional payments will be made for those cases that are high cost outliers. A case will fall into this category if the estimated cost of the case exceeds the outlier threshold (the PPS payment plus fixed loss amount).

- The fixed loss amount is determined such that projected outlier payments are equal to 2 percent of total IPF PPS payments to ensure that IPFs treating unusually costly cases do not incur substantial losses and promote access to IPFs for patients who require expensive care.

- The threshold amount is $5,700.

- If the estimated cost of the case is greater than the adjusted threshold amount ($5700 multiplied by area wage index, rural location, teaching and cost of living adjustment (COLA)), an additional payment will be added to the IPF PPS payment amount.

- Once the threshold amount is met, CMS will share a declining percentage of the losses for a high cost case. The risk-sharing percentages would be 80 percent of the difference between the cost for the case minus payment and the adjusted threshold amount for days 1 through 9 of the stay and 60 percent of the difference after the 9^{th} day. FIs will determine total outlier and divide by number of days, then pay 80% for days 1-9 and 60% for days beyond that.

- Outliers will not be paid on interim bills, but only calculated on the final discharge bill. Outliers will also be calculated on a benefits exhaust bill and if the patient falls under a non-covered level of care.

- Explanation of how to calculate outlier payments:

  1. Calculate the Adjusted Fixed Dollar Loss Threshold
     Threshold amount = $5,700
     Multiply the threshold amount by the labor share (0.72247) and the area wage index.
     Multiply the threshold amount by the non-labor share (0.27753) and any applicable COLA (Alaska or Hawaii).
     Add these two products to the PPS payment to obtain the adjusted threshold amount.

  2. Calculate Eligible Outlier Costs
     Multiply reported hospital charges by the cost-to-charge ratio to calculate cost.
     Subtract the adjusted threshold amount from the cost. This is the amount subject to outlier payments.
     Divide this amount by the length of stay to calculate the per diem outlier amount.

For days 1 through 9, multiply this per diem outlier amount by 0.80. For day 10 and thereafter, multiply the per diem outlier amount by 0.60. The sum of these amounts is the total outlier payment.

Determining the Cost to Charge Ratio

- The IPF PPS outlier methodology requires the FI to calculate the provider's overall Medicare cost-to-charge ratio using the facility's latest settled cost report or tentatively settled cost report (whichever is from the later period), and associated data. Cost-to-charge ratios will be updated each time a subsequent cost report is settled or tentatively settled. Total Medicare charges will consist of the sum of inpatient routine charges and the sum of inpatient ancillary charges including capital. Total Medicare costs will consist of the sum of inpatient routine costs (net of private room differential and swing bed cost) plus the sum of ancillary costs plus capital-related pass-through cost only. Based on current Medicare cost reports and worksheet, specific FI instructions are described below.

- For IPFs that are psychiatric hospitals, Medicare charges will be obtained from Worksheet D-4, column 2, lines 25 through 30, plus line 103 from the cost report. For psychiatric IPFs, total Medicare costs will be obtained from worksheet D-1, Part II, line 49, minus (Worksheet D, Part III, column 8, lines 25 through 30, plus Worksheet D, Part IV, column 7, line 101). Divide the Medicare costs by the Medicare charges to compute the cost-to-charge ratio.

- For IPFs that are distinct part psychiatric units, total Medicare inpatient routine charges will be estimated by dividing Medicare routine costs on Worksheet D-1, Part II, line 41, by the result of Worksheet C, Part I, line 31, column 3 divided by line 31, column 6. Add this amount to Medicare ancillary charges on Worksheet D-4, column 2, line 103 to arrive at total Medicare charges. To calculate the total Medicare costs for distinct part units, data will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, part III, column 8, line 31 plus Worksheet D, Part IV, column 7, line 101). All references to Worksheet and specific line numbers should correspond with the subprovider identified as the IPF unit that is the letter "S" or “M” in the third position of the Medicare provider number. Divide the total Medicare costs by the total Medicare charges to compute the cost-to-charge ratio.

Stop Loss Provision:

IPF PPS includes a stop-loss provision during the 3-year transition.

- The stop-loss provision will be calculated at the time of cost report settlement.

- The stop-loss provision ensures each facility an average payment per case under IPF PPS no less than a minimum proportion of its average payment under the TEFRA.

- In the first year of the transition, 75 percent of total payment would be TEFRA payments, and 25 percent would be IPF PPS payments, which would be guaranteed to be at least 70 percent of

the TEFRA payments. The resulting 92.5 percent of TEFRA payments is the sum of 75 percent and 25 percent times 70 percent (which equals 17.5 percent).

- Example of stop-loss calculation:

1. Enter Total (100%) TEFRA payments for cases during cost reporting period
2. Enter Total (100%) PPS payments for cases during cost reporting period
3. Multiply Step 1 by 0.70.
4. If Step 3 is greater than Step 2, subtract Step 2 from Step 3. Otherwise, enter 0.
5. Add Steps 2 and 4 to calculate total PPS payments.
6. Multiply Step 1 by 0.75 to calculate the TEFRA portion.
7. Multiply Step 5 by 0.25 to calculate the PPS portion.
8. Add Steps 6 and 7 to calculate the IPF's aggregate payments in the first year of the IPF PPS. Determine if this amount is at least 70 percent of what would have been paid under TEFRA, then pay the difference.

Transition (Phase-In Implementation):

- The IPF PPS will be phased-in over 3 years from the cost based reimbursement to the Federal prospective payment.

- All IPF providers must transition over the 3-year transition period. There is NO election of 100 percent PPS in the first year.

- During the transition period, payment is based on an increasing percentage of the IPF prospective payment and a decreasing percentage of each IPFs cost-based reimbursement rate for each case as follows:

Transition Year	Cost Reporting Periods Beginning on or After	TEFRA Rate Percentage	IPF PPS Federal Rate Percentage
1	January 1, 2005	75	25
2	January 1, 2006	50	50
3	January 1, 2007	25	75
	January 1, 2008	0	100

PLEASE NOTE: THE 3-YEAR TRANSITION PERIOD IS SEPARATE FROM THE ANNUAL UPDATE CYCLE. THE TRANSITION IS EFFECTIVE ACCORDING TO COST REPORTING PERIODS.

New IPF Providers:

A new IPF provider is one that meets the criteria for IPFs set forth in § 412.22, 412.23, 412.25, and 412.27 under present or previous ownership or both and their first cost reporting period begins on or after January 1, 2005.

- The new provider will not participate in the 3-year transition from cost based reimbursement to a PPS payment.

- New providers will be paid 100 percent of the IPF PPS Federal rate.

- New providers will not participate in the 3-year transition from cost based reimbursement to a PPS payment since they do not have an established TEFRA amount. New IPF providers will be paid 100 percent of the PPS payment from its first cost reporting period as an IPF beginning on or after January 1, 2005, the effective date of the IPF PPS. Therefore, new providers are not eligible for the stop-loss provision.

C. CLAIMS PROCESSING AND BILLING

Processing Bills Between January 1, 2005 and the Implementation Date of April 4, 2005

Claims submitted prior to implementation will be processed under the current methodology. On or after April 4, 2005, fiscal intermediaries shall mass adjust claims under the IPF PPS payment methodology**. Mass adjustments should be completed by July 1, 2005.**

- We will not have in place before April 4, 2005, the standard computer systems changes necessary to accommodate claims processing and payment under the IPF PPS.
- IPFs must follow the billing requirements as if they're being paid under the PPS so that adjustments can be made accurately and timely.

Billing Requirements Under IPF PPS

Billing IPF PPS Services

Effective with cost reporting periods beginning on or after January 1, 2005, IPFs must incorporate the following so that Fiscal Intermediaries (FIs) can accurately price and pay a claim under the IPF PPS. These claims must be submitted on Type of Bill 11X. The provider number ranges for IPFs are from xx-4000 – xx-4499, xx-Sxxx, and xx-Mxxx .

- The IPF must code correctly; using ICD-9-CM codes based on the principal diagnosis, up to eight additional diagnoses, and one principle procedure and up to five additional procedures performed during the stay, as well as age, sex, and discharge status of the patient on the claim. Grouper 22.0 will determine DRG assignment.

- IPF providers will submit one admit through discharge claim for the stay upon discharge. IPFs may interim bill in 60-day intervals following the instructions in Pub. 100-04, Chapter 1, Section 50.2 should the patient's stay be exceptionally long. Final PPS payment is based upon the discharge bill.

- IPFs can submit adjustment bills, but late charge bills will not be allowed.

- All patient status i.e. discharge disposition codes for 11X Type of Bill are valid, but there are no special payment policies related to transfers; for example, discounted or per diem payments in transfer situations. The same patient status codes applicable under inpatient PPS for same day transfers (with Condition Code 40) are applicable under IPF PPS.

- IPFs will indicate on their claims, under "Revenue Code" 0901 the total number of ECT treatments provided to the patient during their IPF stay listed under "Service Units." Providers will code ICD-9-CM procedure code 94.27 in the procedure code field and use the date of the last ECT treatment the patient received during their IPF stay.

- IPFs continue to be subject to the 1-day payment window for outpatient bundling rules.

  - The payer at the patient's admission to an IPF is responsible for the patient's entire stay.

    For example, an IPF has a patient who moves from traditional Medicare to a Medicare Advantage plan or vise versa, during the patient's stay at the IPF, the payer at admission is responsible for the patient's entire stay.

  - IPFs shall bill for the interrupted stay using Occurrence Span Code 74. The Occurrence Span Code FROM date equals the day of discharge for the IPF and the THROUGH date is the last day the patient was not present in the IPF at midnight. For example, patient leaves IPF on 1/1 and returns to the IPF on 1/3. This is considered an interrupted stay and the Occurrence span code 74 will show 1/1 – 1/2. Should the patient return to the IPF on 1/4, two bills will be allowed. The accommodation revenue code 018X (RT 50, field 5), (SV 201), (leave of absence) will continue to be used in the current manner in terms of Occurrence Span code 74 (RT 40, field 22 – 27) and date range.

  - There are no grace days allowed under IPF PPS, therefore the date the beneficiary is notified of the your intent to bill (Occurrence Code 31) is the last covered day for that patient.

Stays Prior to and Discharge After PPS Implementation Date

If the patient's stay begins prior to and ends on or after the provider's first fiscal year begin date under IPF PPS, payment to the facility is based on IPF PPS rates and rules. There is no split billing. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment (see Pub. 100-04 of the Internet Only Manual, Chapter 1, Section 50.2). If the facility submitted multiple interim bills, the facility will need to submit cancels for all bills and then rebill once the cancels are accepted.

If the beneficiary's benefits were exhausted or patient is in a non-covered level of care prior to implementation of this PPS, then the IPF does not perform this function and will continue to submit no-pay bills (TOB 110) to Medicare.

Current System Edits

- FISS SHALL ENSURE That revenue code total charges line 0001 must equal the sum of the individual total charges lines.

- FISS SHALL ENSURE That the length of stay in the statement covers period, from and through dates, equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence)/interrupted stay.

- FISS and CWF SHALL ENSURE that multiple occurrence span code 74s are allowed.

- CWF SHALL ENSURE That Occurrence Span Code 74 FL36, (RT 40, fields 22,24,26), (2300 loop HI code BI), is present on the claim when there is an interrupted stay (the beneficiary has returned to the IPF within three days).

Billing Ancillary Services Under IPF PPS

When coding PPS bills for ancillary services associated with a IPF inpatient stay, the traditional revenue codes will continue to be shown in FL 42, in conjunction with the appropriate entries in Service Units,

FL46 (SV 205) and Total Charges, FL47 (CLM 02). In general, the current policy applies for billing ancillary services and nothing changes with the implementation of this PPS.

Periodic Interim Payments (PIP)

FIs shall pay PIP for providers that qualify. Outlier payments in regards to PIP will be handled the way they currently are under other inpatient PPS systems. The ECT add-on will also be payable for PIP providers.

Intermediary Benefit Payment Report (IBPR)

The IBPR report will change to reflect the payments for IPFs going to PPS psychiatric hospitals and units.

Monitoring

Additional instructions for monitoring the implementation of IPF PPS through Pulse are as follows:

- Fiscal Intermediary Standard System (FISS) Changes:

  The FISS 620A and 620B reports will be modified to add an additional row for IPF monitoring. The report will be modified to include a separate reporting line titled "IPF PPS." This entry will appear immediately below "IPF PPS" and report the total claim count and total reimbursement amount. IPF PPS totals will include all providers with the last four digits of the provider numbers in range 4000 – 4499, xx-Sxxx, and xx-Mxxx.

Remittance Advices

Reason and remark codes for the ECT add-on will be forthcoming.

Medicare Summary Notices and Explanation of Medicare Benefits

Use existing notices for inpatient hospital PPS.

IPF PRICER Software

CMS has developed an IPF PRICER program that calculates the Medicare payment rate. PRICER software will be electronically supplied to the Standard Systems. A PC version of this PRICER will be available on the CMS website in the future. This will be announced at a later date when available.

PRICER will incorporate the three-year phase-in period for all current IPFs. New IPFs will be paid completely under the new IPF PPS (i.e. there is no transition for new IPFs).

Inputs/Outputs to PRICER

NOTE: As programming progresses, inputs and outputs to Pricer are subject to change.

Inputs

- Provider Specific File Data

Data Element	Title

1	National Provider Identifier (not a mandatory entry at this time)
3	Provider Oscar Number
4	Effective Date
5	Fiscal Year Begin Date
6	Report Date
7	Termination Date
8	Waiver Indicator
10	Provider Type (must be 03 or 06)
13	Actual Geographic Reclassification-MSA
18	Temporary Relief Indicator (For IPF PPS, code Y if there is an Emergency Department)
19	Federal PPS Blend Indicator (must be 1, 2, 3, or 4)
21	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate (This is determined using the same methodology that would be used to determine the interim payment per discharge under the TEFRA system if the IPF PPS were not being implemented.)
22	Cost of Living Adjustment (COLA)
23	Intern/Bed Ratio
25	Combined Capital and Operating Cost to Charge Ratio
33	Special Wage Indicator (should be set to 1 if there is a change to the wage index.)
35	Actual Geographic Location Core-Based Statistical Area (CBSA) (not a mandatory entry at this time)
38	Special Wage Index
48	New Hospital

- **Bill Data**

National Provider Identifier	Covered Charges
OSCAR Number	Discharge Date
Patient Age	Other Diagnosis Codes
DRG	Other Procedure Codes
Length of Stay	Indicator for Occurrence Code 31, A3, B3, or C3 to apply outlier to this bill.
Source of Admission	ECT Units
Patient Status Code	Claim Number

Outputs

In addition to returning the above bill data inputs, Pricer will return the following:

Final Payment	National Non-Labor Rate
DRG Adjusted Payment	Federal Rate
Federal Adjusted Payment	Budget Neutrality Rate
Outlier Adjusted Payment	Outlier Threshold
Comorbidity Adjusted Payment	Federal Per Diem Base Rate
Per Diem Adjusted Payment	Standardized Factor
Facility Adjusted Payment	Labor Share
Age Adjusted Payment	Non-Labor Share
Rural Adjusted Payment	COLA
Teaching Adjusted Payment	Day of Stay Adjustment
ED Adjusted Payment	Age Adjustment
ECT Adjusted Payment	Comorbidity Adjustment
Return Code	DRG Adjustment
MSA/CBSA	Rural Adjustment
Wage Index	ECT Adjustment
National Labor Rate	Blend Year Calculation Version

D. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3541.1	FISS shall modify it's system and edits as appropriate to accommodate IPF PPS changes.					X				
3541.2	FISS shall install and pay psychiatric hospital claims with the IPF Pricer upon implementation of the IPF PPS.					X				
3541.2.1	FISS shall pass to Pricer the bill data items as described in this CR.					X				
3541.2.2	FISS shall pass to Pricer the Provider Specific File data.					X				
3541.2.3	FISS shall process Pricer outputs as described in the CR.					X				
3541.3	FISS shall allow for update or entry of the IPF Provider/Provider Specific File.					X				
3541.3.1	FIs shall populate the IPF Provider/Provider Specific file.	X								
3541.4	FIs shall mass adjust psychiatric hospital claims submitted between January 1, 2005 and April 1, 2005 by July 1, 2005.	X								
3541.4.1	FISS shall allow capability to hook claims.					X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3541.5	FISS shall allow IPFs to interim bill every 60 days and then submit adjustments every 60 days until discharged, cut, or benefits exhaust. (See req. 3541.5.1 below).					X				
3541.5.1	FISS shall allow interim billing using Occurrence Code 31, A3, B3, or C3 in the absence of grace days.					X				
3541.6	FISS shall not allow grace days to be used.					X				
3541.6.1	FISS shall ensure that the Occurrence Code 31 date is the last covered day on the claim.					X				
3541.7	FISS shall modify the core and financial systems to accommodate the ECT add-on.					X				
3541.7.1	FISS shall create a bypassable edit to not allow the number of units for ECT to exceed the number of covered days.					X				
3541.7.2	FISS shall ensure that if revenue code 0901 is present, then ICD-9-CM procedure code 94.27 is present.					X				
3541.8	FISS shall allow split billing over PPS begin date only when the bill is a no-pay bill for benefits exhaust or non-covered level of care.					X				
3541.9	FISS shall modify IBPR Pulse reports to include IPFs.					X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3541.10	FISS shall modify financial systems as needed.					X				
3541.11	CWF shall modify it's system and edits as appropriate to accommodate IPF PPS changes.								X	
3541.12	CWF shall continue to subject IPFs to the 1-day payment window.								X	
3541.13	CWF shall allow admit date to determine payer when Medicare Advantage plan has patient for a portion of the billing period.								X	
3541.14	CWF shall reject as an interrupted stay, IPF bills where patient returns to the same IPF within three days of being discharged, i.e. the incoming IPF bill is three days or less than the discharge date of a history claim for the same IPF and vise versa.								X	
3541.14.1	FI shall return claims to provider for correction. The provider shall submit an adjustment to the paid claims adding occurrence span code(s) 74 and dates.	X								

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: Pricer, Provider Specific File, Grouper, and MCE

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: Discharges on or after January 1, 2005 **Implementation Date:** April 4, 2005 **Pre-Implementation Contact(s):** Policy: Jana Petze at (410) 786-9374 Claims processing: Sarah Shirey at (410) 786-0187 **Post-Implementation Contact(s):** Appropriate regional office	**Medicare contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

20.2.3.1 - Provider-Specific File

(Rev. 384, Issued: 12-01-04, Effective: 01-01-05, Implementation: 04-04-05)

The PROV file contains needed information about each provider to enable the pricing software to calculate the payment amount. The FI maintains the accuracy of the data in accordance with the following criteria.

Whenever the status of any element changes, the FI prepares an additional record showing the effective date. For example, when a hospital's FY beginning date changes as a result of a change in ownership or other "good cause," the FI makes an additional record showing the effective date of the change.

The format and data required by the PRICER program and by the provider-specific file is found in Addendum A.

FIs submit a file of provider-specific payment data to CMS CO every three months for PPS and non-PPS hospitals, inpatient rehabilitation hospitals or units (referred to as IRFs), long term care hospitals (LTCHs), *inpatient psychiatric facilities (IPFs),* SNF's, and hospices, including those in Maryland. Regional home healths FIs (RHHIs) submit a file of provider specific data for all home health agencies. FIs serving as the audit FI for hospital based HHAs do not submit a file of provider specific data for HHAs.

FIs create a new record any time a change occurs for a provider. Data must be reported for the following periods: October 2 - January 1, January 2 - April 1, April 2 - July 1, and July 2 - October 1. This file must be received in CO within seven business days after the end of the period being reported.

NOTE: FIs submit the latest available provider-specific data for the entire reporting period to CO by the seven-business day deadline. If CO fails to issue applicable instructions concerning changes or additions to the file fields by 10 calendar days before the end of the reporting period, the FI may delay reporting of data related to the CO instructions until the next file due date. For example, if CO instructions changing a file field are issued on or after September 21 with an effective date of October 1, the FI may exclude the October 1 CO-required changes from the file submitted by October 9. The FI includes the October 1 CO-required changes, and all subsequent changes through January 1 in the file submitted in January.

A - PPS Hospitals

FIs submit all records (past and current) for all PPS providers every three months. Duplicate the provider file used in the "PRICER" module of the claims processing system.

B - Non-PPS Hospitals and Exempt Units

FIs create a provider specific history file using the listed data elements for each non-PPS hospital and exempt hospital unit. Submit the current and the preceding fiscal years every three months. Code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file.

C - Hospice

FIs create a provider specific history file using the following data elements for each hospice. Submit the current and the preceding fiscal years every three months. Data elements 3, 4, 5, 6, 9, 10, 13, and 17 are required. All other data elements are optional for this provider type.

D - Skilled Nursing Facility (SNF)

FIs create a provider specific history file using the following data elements for each SNF beginning with their first cost reporting period that starts on or after July 1, 1998. FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 3, 4, 5, 6, 9, 10, 13, 19, and 21 are required. All other data elements are optional for this provider type.

E - Home Health Agency (HHA)

FIs create a provider specific history file using the following data elements for each HHA. Regional Home Health FIs (RHHIs) submit the current and the preceding fiscal years every three months. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, and 19 are required. All other data elements are optional for this provider type. All fields must be zero filled if not completed. Update the effective date in data element 4 annually. Ensure that the current census division in data element 11 is not zero. Ensure that the waiver indicator in data element 8 is N. Ensure that the MSA code reported in data element 13 is a valid MSA code.

F - Inpatient Rehabilitation Facilities (IRFs)

FIs create a provider specific history file using the following data elements for each IRF beginning with their first cost reporting period that starts on or after January 1, 2002. FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 19, 21, 25, 27, 28, and 42 are required. All other data elements are optional for this provider type

G – Long Term Care Hospital (LTCH)

FIs create a provider specific history file using the following data elements for each LTCH beginning with their first cost reporting period that starts on or after October 1, 2002. FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 19, 21, 22, and 25 are the minimum required fields for entering a provider under LTCH PPS.

H – Inpatient Psychiatric Facilities (IPF)

FIs create a provider specific history file using the following data elements for each IPF beginning with their first cost reporting period that starts on or after January 1, 2005. FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 1, 3, 4, 5, 6, 7, 8, 10, 13, 18, 19, 21, 22, 23, 25,33, 35, 38, and 48 are required. All other data elements are optional for this provider type.

Although data element 25 refers to the operating cost to charge ratio, ensure that both operating and capital cost-to-charge ratio are entered in data element 25 for IPFs. Ensure that data element 21 (Facility Specific Rate) will be determined using the same methodology to determine the interim payment per discharge under the TEFRA system.

NOTE: All data elements, whether required or optional, must have a default value of "0" (zero) if numerical, or a blank value if alphanumerical.

The provider specific file (PSF) should be transferred to CO using the Network Data Mover (NDM) system, COPY TO and RUN JOB statements, which will notify CO of PSF file transfer. FIs must set up an NDM transfer from the FI's system for which it is responsible. It is critical that the provider specific data is copied to the CMS Data Center using the following input data set names ("99999" should be changed to the FI's 5-digit number):

Data set Name ---COPY TO: --MU00.@FPA2175.intermediary99999

DCB=(HCFA1.MODEL,BLKSIZE=2400,LRECL=2400,RECFM=FB)

Data set Name ---RUN JOB: --MU00.@FPA2175.CLIST(intermediary99999)

See <u>Addendum A</u> for the Provider Specific File record layout and description.

Addendum A - Provider Specific File

(Rev. 384, Issued: 12-01-04, Effective: 01-01-05, Implementation: 04-04-05)

A-03-058 (for CCR development)

Data Element	File Position	Format	Title	Description
1	1-8	X(8)	National Provider Identifier (NPI)	Alpha-numeric 8 character Identifier (NPI) Provider number.
2	9-10	X(2)	NPI Filler	Blank.
3	11-16	X(6)	Provider Oscar No.	Alphanumeric 6 character provider number. Cross check to Item 10, provider type. Positions 3 and 4 of: Codes for special units *M, R,* S, T, U, V, W, U and Z are in the third position of the provider number and should be type 06 (hospital distinct parts).
4	17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date. Month 01-12, day 01-31, year greater than 82 but not greater than current year.

Provider #	Type (see field 10)
00-08	Blanks, 00, 07-11, 13-17, 21-22
12	18
13	23,37
20-22	02
30	04
33	05
40-44	03
50-64	32-34, 38
15-17	35
70-84, 90-99	36

Data Element	File Position	Format	Title	Description
5	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD Day: 01-31, Month: 01-12 Year: Greater than 81, but not greater than current year. Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date (Field #4 above).
6	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
7	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting FI ceased servicing the provider. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. If the provider is terminated or transferred to another FI, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing FI. Likewise, if the provider identification number changes, the FI must place a termination date in the PROV file transmitted to CO for the old provider identification number.
8	49	X	Waiver Indicator	Provider waived from PPS? Must be Y (yes) or N (no). Y = means waived (Provider is not under PPS). N = means not waived (Provider is under PPS).
9	50-54	9(5)	Intermediary Number	Assigned intermediary number.

Data Element	File Position	Format	Title	Description
10	55-56	X(2)	Provider Type	This identifies providers that require special handling. The FI enters the appropriate code: Must be blank or 00, 02-08, 13-18, 21-23, or 32-38. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (During cost reporting periods that began on or after 4-1-90.) 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after 4-1-90. Invalid 10/1/94 through 90-30-97. See §20.6B.) 16 Rebased Sole Community Hospital 17 Rebased Sole Community Hospital/Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital (EACH) 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demonstration Project - Phase II (SNF only) 33 Nursing Home Case Mix Quality Demonstration Project - Phase III Step 1 (SNF only) 34 Reserved

Data Element	File Position	Format	Title	Description
				35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) - For Non demo PPS SNF's - eff. for cost reporting periods beginning on or after 7/1/98.
11	57	9	Current Census Division	Must be numeric (1-9). The Census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, FIs must change the census division to reflect the new standardized amount location. Valid codes are: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 8 Mountain 9 Pacific
				NOTE: When a facility is reclassified for purposes of the standard amount, the FI Changes the census division to reflect the new standardized amount location.
12	58	X	Change Code Wage Index Reclassification	Enter "Y" if hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually.
13	59-62	X(4)	Actual Geographic Location - MSA	Enter the appropriate code for the MSA 0040-9965, or the rural area, (blank) (blank) 2 digit numeric State code such as

Data Element	File Position	Format	Title	Description
				_ _36 for Ohio, where the facility is physically located.
14	63-66	X(4)	Wage Index Location - MSA	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location MSA (field 13), if not reclassified. PRICER will automatically default to the actual location MSA if this field is left blank.
15	67-70	X(4)	Standardized Amount MSA Location	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for standardized amount. Leave blank or enter the actual location MSA (field 13) if not reclassified. PRICER will automatically default to the actual location MSA if this field is left blank
16	71-72	X(2)	Sole Community or Medicare Dependent Hospital – Base Year	Leave blank if not a sole community hospital (SCH) or a Medicare dependent hospital (MDH) effective with cost reporting periods that begin on or after April 1, 1990. If an SCH or an MDH, show the base year for the operating hospital specific rate, the higher of either 82 or 87. See §20.6. Must be completed for any SCH or MDH that operated in 82 or 87, even if the hospital will be paid at the Federal rate.
17	73	X	Change Code for for Lugar reclassification	Enter an "L" if the MSA has been reclassified for wage index purposes under §1886(d)(8)(B) of the Act. These are also known as Lugar reclassifications, and apply to ASC-approved services provided

Data Element	File Position	Format	Title	Description
				on an outpatient basis when a hospital qualifies for payment under an alternate wage index MSA. Leave blank for hospitals if there has not been a Lugar reclassification.
18	74	X	Temporary Relief Indicator	Enter a 'Y' if this provider qualifies for a payment update under the temporary relief provision, otherwise leave blank. *IPPS: Effective October 1, 2004—code a Y if the provider is considered "low volume".* *IPF PPS: Effective January 1, 2005, code a Y if the acute facility where the unit is located has an Emergency Department or if the freestanding psych facility has an Emergency Department.*
19	75	X	Federal PPS Blend Indicator	HHA: Enter the code for the appropriate percentage payment to be made on HH PPS RAPs. Must be present for all HHA providers, effective on or after 10/01/2000 0 = Pay standard percentages 1 = Pay zero percent All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002. LTCH: Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2002. 1 — Federal % 20 — Facility% 80 2 — 40 — 60 3 — 60 — 40

Data Element	File Position	Format	Title	Description
				4 80 20 5 100 00
				IPF: Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all IPF providers with cost reporting periods beginning on or after 1/1/2005. *Federal % Facility%* *1 25 75* *2 50 50* *3 75 25* *4 100 00*
20	76-89	X(5)	Filler	Blank.
21	81-87	9(5)V9(2)	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate	For PPS hospitals and waiver state non-excluded hospitals, enter the base year cost per discharge divided by the case mix index. Enter zero for new providers. See §20.1 for sole community and Medicare-dependent hospitals on or after 04/01/90. For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000.
22	88-91	9V9(3)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.

Data Element	File Position	Format	Title	Description
23	92-96	9V9(4)	Intern/Beds Ratio	Enter the provider's intern/resident to bed ratio. Calculate this by dividing the provider's full time equivalent residents by the number of available beds (as calculated in positions 97-101). Do not include residents in anesthesiology who are employed to replace anesthetists or those assigned to PPS excluded units. Base the count upon the average number of full-time equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. The FI is responsible for reviewing hospital records and making necessary changes in the count at the end of the cost reporting period. Enter zero for *non-teaching* hospitals.
24	97-101	9(5)	Bed Size	Enter the number of adult hospital beds and pediatric beds available for lodging inpatient. Must be greater than zero. (See the Provider Reimbursement Manual, §2405.3G.)
25	102-105	9V9(3)	Operating Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by the Medicare covered charges. Obtain Medicare operating costs from the Medicare cost repot form CMS-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare covered charges from the FI billing file, i.e., PS&R record. For hospitals for which the FI is unable to compute a reasonable cost-to-charge ratio, they use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." These average ratios are used to calculate cost outlier payments for those hospitals where you

Data Element	File Position	Format	Title	Description
				compute cost-to-charge ratios that are not within the limits published in the "Federal Register." For LTCH, *IPF* and IRF PPS, a combined operating and capital cost-to-charge ratio is entered here. See below for a discussion of the use of more recent data for determining CCRs.
26	106-110	9V9(4)	Case Mix Index	The case mix index is used to compute positions 81-87 (field 21). Zero fill for all others. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
28	115-118	V9(4)	Medicaid Ratio	Enter the Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
29	119	X	Provider PPS Period	This field is obsolete as of 4/1/91. Leave Blank for periods on or after 4/1/91
30	120-125	9V9(5)	Special Provider Update Factor	Zero fill for all hospitals after FY91. This Field is obsolete as of FY92.
31	126-129	V9(4)	Operating DSH	Disproportionate share adjustment Percentage. PRICER calculates the Operating DSH effective 10/1/91 and bypasses this field. Zero fill for all hospitals 10/1/91 and later.

Data Element	File Position	Format	Title	Description
32	130-137	9(8)	Fiscal Year End	This field is no longer used. If present, must be CCYYMMDD
33	138	X(1)	Special Payment Indicator	Code indicates the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified
34	139	X(1)	Hospital Quality Indicator	Code *indicates* hospital meets criteria to receive higher payment per MMA quality standards. 1 = hospital quality standards have been met
35	140-144	X(5)	Actual Geographic Location Core-Based Statistical Area (CBSA)	Enter the appropriate code for the CBSA 00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located.
36	145-149	X (5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank) (blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field 35) if not reclassified. PRICER will automatically default to the actual location CBSA if this field is left blank

Data Element	File Position	Format	Title	Description
37	150-154	X (5)	Standardized Amount Location CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank) (blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified. Leave blank or enter the actual location CBSA (field 35) if not reclassified. PRICER will automatically default to the actual location CBSA if this field is left blank
38	155-160	9(2) V9 (4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless field 33 = "1" or "2"
39	161-166	9(4) V99	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. Ust be zero if location 185 = A, B, or C (See the Provider Reimbursement Manual, §2405.2). Used for PPS hospitals prior to their cost reporting period beginning in FY 92, new hospitals during their first 2 years of operation FY 92 or later, and non-PPS hospitals or units. Zero fill if this does not apply.
40	167-172	9(4) V99	Pass Through Amount for Direct Medical Education	Per diem amount based on the interim payments to the hospital (See the Provider, Reimbursement Manual, §2405.2.). Zero fill if this does not apply.
41	173-178	9(4) V99	Pass Through Amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart, and liver transplants. Do not include acquisition costs for bone marrow transplants. (See the Provider Reimbursement Manual, §2405.2.) Zero fill if this does not apply.

Data Element	File Position	Format	Title	Description
42	179-184	9(4) V99	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital (See the Provider Reimbursement Manual §2405.2.) Must be at least equal to the three pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts. Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year, and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, or DSH adjustments. Zero fill if this does not apply.
43	185	X	Capital PPS Payment Code	Type of capital payment methodology for hospitals: A = Hold Harmless – cost payment for old capital B = Hold Harmless – 100% Federal rate C = Fully prospective blended rate Must be present unless a "Y" is entered in location 49 (position 207), or 08 is entered in location 55-56 or a termination date is present in location 41-48.
44	186-191	9(4) V99	Hospital Specific Capital Rate	Enter the hospital's allowable adjusted base year inpatient capital costs per discharge. This field is not used as of 10/1/02.
45	192-197	9(4) V99	Old Capital Hold Harmless Rate	Enter the hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.

Data Element	File Position	Format	Title	Description
46	198-202	9V9(4)	New Capital-Hold Harmless Ratio	Enter the ratio of the hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.
47	203-206	9V999	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the FI is unable to compute a reasonable cost-to-charge ratio, it uses the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard deviation band. The FI uses the hospital's ratio rather than the statewide average if it agrees the hospital's rate is justified. See below for a detailed description of the methodology to be used to determine the CCR for Acute Care Hospital Inpatient and LTCH Prospective Payment Systems.
48	207	X	New Hospital	Enter "Y" for the first 2 years that a new hospital is in operation. Leave blank if *the period is more than two years after the provider accepted its first patient.*
49	208-212	9V9(4)	Capital Indirect Medical Education Ratio	Enter the ratio of residents/interns to the hospital's average daily census. Calculate by dividing the hospital's full-time equivalent total of residents during the fiscal year by the hospital's total inpatient days. See §20.4.1 above.) Zero fill for a non-teaching hospital.
50	213-218	9(4) V99	Capital Exception Payment Rate	The per discharge exception payment to which a hospital is entitled. (See §20.4.7 above.)
51	219-240	X (22)	Filler	Blank.

Methodology for Determining Payment for Outliers Under the Acute Care Hospital Inpatient and LTCH Prospective Payment Systems

Use of More Recent Data for Determining CCRs

A. Changing CCRs For Hospitals Subject to the IPPS

Under 42 CFR 412.84(i)(1), if more recent charge data indicate that a hospital's charges have been increasing at an excessive rate (relative to the rate of increase among other hospitals), as explained below, CMS may direct the FI to change the hospital's operating and capital CCRs to reflect the high charge increases evidenced by the later data. A hospital may also request that its FI use a different (higher or lower) CCR based on substantial evidence presented by the hospital. Before a change based on a hospital's request can become effective, the CMS Regional Office must approve the change.

FIs are to perform data analysis to identify those hospitals that appear to have disproportionately benefited from the time lag in updating the CCRs using the latest settled cost reports. These are hospitals:

1. With FY 2003 operating outlier payments of at least 10 percent of total operating diagnosis-related group (DRG) payments plus operating outlier payments;
2. Whose operating outlier payments relative to total operating DRG payments increased by at least 20 percent from either FY 2001 to FY 2002, or FY 2002 to FY 2003; and
3. Whose average charges per case increased by at least 15 percent both from FY 2000 to FY 2001, and from FY 2001 to FY 2002.

FIs are also to perform data analysis to identify hospitals that received operating outlier payments in excess of 100 percent of total operating DRG payments for FY 2003 (outlier payments divided by DRG payments).

Effective for discharges occurring on or after August 8, 2003, for hospitals that are identified through the above data analysis, FIs are to use an alternative CCR rather than one based on the latest settled cost report (such as a CCR based on data from the latest tentative settled cost report or more recent data) to identify and pay for outliers under the IPPS. By July 25, 2003, for each of the hospitals identified, FIs should calculate a capital and operating CCR using the alternative data and submit this ratio to CMS (to the attention of Michael Treitel, e-mail at mtreitel@cms.hhs.gov). CMS will notify FIs whether to use these ratios or an alternative ratio. For all IPPS claims processed on or after August 8, 2003, until more accurate data becomes available, FIs are to use this approved alternative ratio.

B. Use of Alternative Data in Determining CCRs For Hospitals Subject to the IPPS and For Hospitals Subject to the LTCH PPS

Under 42 CFR 412.84(i)(1) of the IPPS and 42 CFR 412.525(a)(4)(ii), 42 CFR 412.529(c)(5)(ii) of the LTCH PPS, CMS may direct FIs to use an alternative CCR to the CCRs from the later of the latest settled cost report or latest tentative settled cost report), if CMS believes this will result in a more accurate CCR. In addition, if the FI finds evidence that indicates that using data from the latest settled or tentatively settled

cost report would not result in the most accurate CCR, then the FI should contact CMS to seek approval to use a CCR based on alternative data.

Also, a hospital may request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The hospital is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The CMS Regional Office must approve any such request after evaluation by the fiscal intermediary of the evidence presented by the hospital.

C. Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the IPPS and For Hospitals Subject to the LTCH PPS

For discharges beginning on or after October 1, 2003, FIs use CCRs from the latest settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine a hospital's operating and capital CCRs. By October 1, 2003, for all hospitals that are paid under the IPPS or LTCH PPS, FIs must have updated CCRs on the Provider Specific File (PSF) to reflect CCRs from the most recent tentative settlements or final settled cost reports, (whichever is the later period). These updated CCRs are used to process claims with discharge dates on or after October 1, 2003. The CCR on the PSF must be updated when that cost report is settled or when a cost report for a subsequent cost reporting period is tentatively settled, whichever is the latest cost reporting period.

In order to arrive at CCRs to be used in the PSF based on tentative settlement data, the FI should review previous adjustments used (if any) in the tentative settlement and take into consideration the impact of prior audit adjustments on prior period CCRs to determine if they had an impact on the CCRs. If these tentative settlement adjustments have no impact on the CCRs, or if no adjustments were made, the tentative settled CCRs will equal the CCRs from the hospital's as-filed cost report. If the adjustments made at tentative settlement would have an impact on the CCRs, the FI should compute new CCRs based on the tentative settlement. (Note: If the tentative settlement adjustments result in a difference in the CCR from the as filed cost report of 20 percent or less, then no adjustment to the CCR at tentative settlement is necessary.)

Following the initial update of CCRs for all hospitals for discharges on or after October 1, 2003, FIs should continue to update a hospital's operating and capital CCRs each time a more recent cost report is tentatively settled. Revised CCRs must be entered into the PSF not later than 45 days after the date of the tentative settlement or final settlement used in calculating the CCRs. Subject to the approval of CMS, CCRs may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs or charges. Revised CCRs will be applied prospectively to all IPPS and LTCH PPS claims processed after the update.

II. Statewide Average for Hospitals Subject to the IPPS and for Hospitals Subject to the LTCH PPS

Prior to August 8, 2003, hospitals were assigned a statewide average CCR if their actual operating or capital CCR fell outside 3 standard deviations from the respective national geometric mean CCR.

Effective August 8, 2003, a hospital is longer be assigned the statewide average CCR when the hospital has a CCR that falls below 3 standard deviations from the national mean. Hospitals receive their actual CCRs, no matter how low their ratios fall.

The statewide average CCRs may still apply in those instances in which a hospital's operating or capital CCRs exceed the upper threshold. In addition, hospitals that have not yet filed their first Medicare cost report may still receive the statewide average CCRs. CMS will continue to set forth the upper threshold (i.e., 3 standard deviations above the national geometric mean CCR) and the statewide CCRs applicable to IPPS hospitals and LTCHs in each year's annual notice of prospective payment rates published in the "Federal Register."

III. Reconciling Outlier Payments For Hospitals Subject to the IPPS and For Hospitals Subject to the LTCH PPS

For the hospitals under the IPPS for which the FI applied alternative CCRs for discharges occurring on or after August 8, 2003 (that were identified through the above 3-step data analysis), and, for discharges occurring in cost reporting periods beginning on or after October 1, 2003 for all other IPPS hospitals, FIs reconcile outlier payments at the time of cost report final settlement if:

1. Actual operating or capital CCRs are found to be plus or minus 10 percentage points from the CCRs used during that time period to make outlier payments, and
2. Total outlier payments in that cost reporting period exceed $500,000.

Consistent with the June 9, 2003 Federal Register (68 FR 34504) in which CMS indicated that it intended to issue program instructions that would provide specific criteria for identifying those hospitals subject to reconciliation for the remainder of FY 2003 and for FY 2004, these criteria allow FIs to focus their limited resources on only those hospitals that appear to have disproportionately benefited from the time lag in updating their CCRs. Similarly, for hospitals subject to the LTCH PPS, for discharges occurring in cost reporting periods beginning on or after October 1, 2003, reconciliation should be made if:

1. Actual operating CCRs are found to be plus or minus 10 percentage points from the CCRs used during that cost reporting period to make outlier payments, and
2. High cost outlier payments made under 412.525 and short stay outlier payments made under 42 CFR 412.529 combined exceed $500,000 in that cost reporting period.

The return codes from the PRICER software may be used to identify the cases for which high cost outlier and/or short stay outlier payments were made in a cost reporting period.

If the above criteria for IPPS hospitals and LTCHs do not identify additional hospitals that are being similarly overpaid (or underpaid) significantly for outliers, then, based on an analysis of the hospital's most recent cost and charge data that indicates that CCRs for those hospitals are significantly inaccurate, FIs have the administrative discretion to reconcile cost reports of those additional IPPS hospitals and LTCHs. However, FIs must seek approval from their CMS Regional Office in the event they intend to reconcile

outlier payments for an IPPS hospital or a LTCH that does not meet the above-specified criteria.

IV. Notification to Hospitals under the IPPS and the LTCH PPS

FIs are to notify a hospital whenever they make a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR should be included in the notice that is issued to each provider after a tentative or final settlement is completed.